

## KANSAS MEDICAID PRIOR AUTHORIZATION

Fentanyl Citrate
Actiq®, Fentora®, Lazanda®,
Onsolis® Abstral®

Request Date									
	/			/					

	Onsolis®, Abstral®									
Beneficiary Medicaid ID Number	BENEFICIARY INFORMATION	Beneficiary Date of Birth								
Beneficiary Full Name										
Prescriber's Full Name	PRESCRIBER INFORMATION									
Prescriber Street Address										
City	State	Zip Code								
Prescriber Phone:	Prescr	iber Fax:								
Prescriber Medicaid ID #		Prescriber NPI #								
NDC Requested:	<b>–</b>									
	Length of Therapy									
StrengthQuantity on Prescription										
Prescription instructions(sig):	Prescription instructions(sig):									
Diagnosis for use of this medication (do not use dx codes):										
Is the Prescriber an Oncologist? Yes ( ) No ( )										
Is the Prescriber a Pain Specialist? Yes ( ) No ( )										
Is the patient, prescriber and pharmacy enrolled in the FOCUS for REMS program management? Yes()No()										
Current Opioid therapy:										
All other medications patient is currently taking										
Signature of Prescriber										
	*Prescriber signature mandatory	Date								

FAX TO: KANSAS Medicaid Prior Authorizations Fax: (866) 246-8512 PA HELPDESK: (877) 475 - 7567 18405

